TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Trauma and Emergency Care

Respondent Name
City of Tyler

MFDR Tracking Number
M4-17-3863-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 28, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Records were mailed 11/23/2016, 03/28/2017 and 06/27/2017."

Amount in Dispute: $629.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although the provider has submitted a copy of a fax cover sheet that was sent to another entity on 11/23/17 [sic], there has been no documentation provided as to what was included in the fax, or a copy of an EOB or letter advising the provider the bill was filed to them incorrectly, or when it was discovered Claims Administrative Services was the correct carrier. Had the provider documented any of this to us when they discovered the bill was filed incorrectly, consideration would have been made. It is our position denial should be maintained as provider has not provided satisfactory documentation for timely filing."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2016	99284	$629.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out medical bill submission procedures for health care providers.
3. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
4. Texas Labor Code §408.0272 provides certain exceptions for untimely submission of a medical bill.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 719 – Per Rule 133.20, a medical bill shall not be submitted later than the 95th day after the date of service
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 350 – Bill has been identified as a request for reconsideration or appeal

Issues

1. Did the requestor support timely submission of the medical bill?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

1. The requestor is seeking reimbursement for Code 99284 – "Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function" in the amount of $629.00 for date of service November 19, 2016.

   The requestor states, "Claim was original sent 877-219-0832." Review of the submitted documentation found a fax confirmation that on November 23, nine pages were sent to this number. The name "CMI" is listed on this fax cover page. No evidence was found to support this carrier received and processed the medical bill for the service in dispute.

   Review of the carrier associated with the injured employees' employer is found to be Claims Administrative Services. Evidence was found to support that a medical bill was submitted to Claims Admin Services on March 23, 2017. This date is found on the submitted CMS 1500 medical bill and a fax confirmation for this carrier. The carrier acknowledged receipt of this claim on March 23, 2017.

   Based on our review the Division finds insufficient evidence to support the medical bill was received and processed by CMI. However, sufficient evidence was found to support the medical bill was received and processed by Claims Admin Services. The requestor's statement is not supported. The service in dispute will be reviewed based on the supported submission of medical services.

2. The insurance carrier denied disputed services with claim adjustment reason code 29 – The time limit for filing has expired." 28 Texas Administrative Code §133.20 (b) states,

   > Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied.

   Texas Labor Code §408.0272(b) provides certain exceptions to the 95-day time limit for bill submission:

   > Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:

(1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:
   (A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
   (B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
   (C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the health care provider was required to submit the medical bill not later than the 95th day following the date the disputed services were provided. The carrier's denial is supported. No additional payment is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 21, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.